This is only a summary of medical benefits. You also have valuable benefits that are described in the pharmacy summary of benefits and coverage ("Pharmacy SBC.") You should read this summary (the "Medical SBC") and the Pharmacy SBC together. If you want more detail about your coverage and costs, you can get the complete terms by visiting the Plan Documents page of the DCH website: www.dch.georgia/shbp or by calling 1-855-641-4862.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**Deductible** — **In-network:** — **Out-of-network:** • You — $ 1,500 — $ 3,000 • You + Child(ren) — $ 2,150 — $ 4,500 • You + Spouse — $ 2,150 — $ 4,500 • You + Family — $ 3,000 — $ 6,000 **HRA Account** — **Initial Dollars:** — **Plus Earned:** • You — $400 — + $480 = $880 • You+Child(ren) — $600 — + $480 = $1,080 • You+Spouse — $600 — + $960 = $1,560 • You+Family — $800 — + $960 = $1,760	You must pay all the costs up to the annual **deductible** amount before this plan begins to pay for covered services you use. This plan has a separate **deductible** for in-network providers and out-of-network providers. The deductible starts over January 1st. See the chart starting on page 3 for how much you pay for covered services after you meet the **deductibles.** • Only costs for **allowed amounts** count toward your deductible. Costs you pay for pharmacy expenses do not count toward the **deductibles**. • Your costs are first paid from your HRA Account. SHBP funds an initial amount, and you (and your covered spouse) can each earn additional HRA dollars by completing 2014 well-being activities. If you or your covered spouse (or both of you) were enrolled in any non-Medicare Advantage option of the SHBP in 2013 and completed the 2013 wellness requirements, additional dollars will be added to your HRA Account on 1/1/2014 ($240 per person completing the requirements).
Are there other deductibles for specific services?	No. There are no **deductibles** for specific services.	You don't have to meet **deductibles** for specific services but see the chart starting on page 3 for other costs for services this plan covers (coinsurance).
Is there an out–of–pocket limit on my expenses?	**In-network:** — **Out-of-network:** • You — $ 4,000 — $ 8,000 • You + Child(ren) — $ 6,000 — $ 12,000 • You + Spouse — $ 6,000 — $ 12,000 • You + Family — $ 8,000 — $ 16,000	The out-of-pocket limit is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.

What is not included in the out–of–pocket limit?	Premiums, balance-billed charges, pharmacy expenses, and other services the medical benefits component of this plan does not cover.	Even though you may pay these expenses, they don't count toward the out-of-pocket limit.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 3 describes any limits on what the plan will pay for specific covered services, such as office visits. For more information, see the Plan Documents.
Does this plan use a network of providers?	Yes. Within the State of Georgia, the network is the Open Access POS. Outside the State of Georgia, it is the Blue Card PPO. See **www.bcbsga.com/shbp** or call 1-855-641-4862 for a list of in-network providers.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their network. The **allowed amount** for out-of-network providers is usually 110% of the Medicare rate for the service. In most cases, the plan does not accept assignment of benefits from out-of-network **providers**, and pays benefits directly to you. It is your responsibility to forward the payment to the out-of-network **provider,** and you may be **balance-billed**. See the chart starting below for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No.	You can see the **specialist** you choose without permission from this plan or your primary care physician.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your plan document for additional information about **excluded services**.

- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight in-network hospital stay is $1,000, your **coinsurance** payment of 15% would be $150 after you have satisfied your in-network deductible.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference in addition to your deductible and coinsurance. (This is called **balance billing**.)
- By using in-network providers, you will have lower **deductibles, coinsurance, and out-of-pocket maximums.**

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	15% **coinsurance**	40% **coinsurance**	There are childhood obesity visit limits.
	Specialist visit	15% **coinsurance**	40% **coinsurance**	None
	Other practitioner office visit	15% **coinsurance** for chiropractor	40% **coinsurance** for chiropractor	Coverage is limited to 20 visits per plan year for chiropractor. There are visit limits for registered dietitians.
	Preventive care/screening/immunization	No cost share for covered services properly coded as preventive care and provided by an in-network provider.	Not covered*	*Exception - hospital based radiologist and anesthesiologist services provided by an out-of-network provider at an in-network facility and properly coded as preventive care are paid at 100% of **allowed amount**.
If you have a test	Diagnostic test (x-ray, blood work)	15% **coinsurance**	40% **coinsurance**	None
	Imaging (CT/PET scans, MRIs)	15% **coinsurance**	40% **coinsurance**	Pre-certification may be required.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available in the Pharmacy SBC	Generic drugs	See Pharmacy SBC.		See Pharmacy SBC.
	Preferred brand drugs	See Pharmacy SBC.		See Pharmacy SBC.
	Non-preferred brand drugs	See Pharmacy SBC.		See Pharmacy SBC.
	Specialty drugs	See Pharmacy SBC.		See Pharmacy SBC.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	15% **coinsurance**	40% **coinsurance**	Pre-certification may be required.
	Physician/surgeon fees	15% **coinsurance**	40% **coinsurance**	Some **providers** are not covered as assistants at surgery. Pre-certification may be required.
If you need immediate medical attention	Emergency room services	15% **coinsurance** for emergency care		None
	Emergency medical transportation	15% **coinsurance**		None
	Urgent care	15% **coinsurance**	40% **coinsurance**	None

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you have a hospital stay	Facility fee (e.g., hospital room)	15% **coinsurance**	40% **coinsurance**	Pre-certification may be required.
	Physician/surgeon fee	15% **coinsurance**	40% **coinsurance**	Some **providers** are not covered as assistants at surgery. Pre-certification may be required.
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	15% **coinsurance**	40% **coinsurance**	Failure to obtain pre-certification may result in non coverage or reduced benefits.
	Mental/Behavioral health inpatient services	15% **coinsurance**	40% **coinsurance**	See above
	Substance use disorder outpatient services	15% **coinsurance**	40% **coinsurance**	See above
	Substance use disorder inpatient services	15% **coinsurance**	40% **coinsurance**	See above
If you are pregnant	Prenatal and postnatal care (includes doctor's charges for delivery)	15% **coinsurance**	40% **coinsurance**	Charges for delivery are part of prenatal and postnatal care. Pre-certification may be required.
	Delivery and all inpatient services	15% **coinsurance**	40% **coinsurance**	Applies to inpatient facility. Other cost sharing may apply depending on the services provided.
If you need help recovering or have other special health needs	Home health care	15% **coinsurance**	40% **coinsurance**	Pre-certification may be required.
	Rehabilitation services	15% **coinsurance**	40% **coinsurance**	Rehabilitation visit limit of 40 visits per plan year combined in and out-of-network, for each - occupational, physical, speech, pulmonary, and cardiac rehabilitation.
	Habilitation services	15% **coinsurance**	40% **coinsurance**	Habilitation visits count toward the rehabilitation visit limit above.
	Skilled nursing care	15% **coinsurance**	Not covered	Limit of 120 days per plan year for facility services. Pre-certification may be required.
	Durable medical equipment	15% **coinsurance**	40% **coinsurance**	Pre-certification may be required.
	Hospice service	15% **coinsurance**	40% **coinsurance**	Pre-certification may be required.

If your child needs dental or eye care	Eye exam	No cost share	Not covered	Limit of one routine exam every 24 months.
	Glasses	Not covered	Not covered	None
	Dental check-up	Not covered	Not covered	None

Excluded Services & Other Covered Services:

Some Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for excluded services.)

- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Elective abortion (except when the life of the mother is at risk)
- Infertility treatment
- Private-duty nursing
- Long-term custodial hospital care
- Routine dental care
- Routine foot care
- Weight loss programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services, limitations, and your costs for these services.)

- Chiropractic care
- Hearing aid (limitations apply)
- Most coverage provided outside the United States. www.bcbs.com/bluecardworldwide.
- Non-emergency care when traveling outside the U.S.

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a premium, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1 800-610-1863. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 ext. 61565 or www.cciio.com.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for medical claims under your plan, you may be able to **appeal** or file a **grievance**. You should contact Blue Cross Blue Shield of Georgia directly to appeal denial of coverage for medical claims by calling 1-855-641-4862. For appeals related to HRA Account dollars earned in 2014, contact Healthways, Inc. at 1-888-616-6411. For questions about your eligibility, rights, this notice, or assistance, you can contact: the State Health Benefit Plan Call Center at 1-800-610-1863 or access information about eligibility appeals at www.dch.georgia.gov/shbp.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **The plan, which includes medical and well-being benefits described in the Medical SBC and Pharmacy benefits described in the Pharmacy SBC does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-855-641-4862

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. These examples include costs for pharmacy benefits. For more information about pharmacy benefits, see the Pharmacy SBC. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

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This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $5,020*
- **Patient pays** $2,520*

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$1,500
Copays	$0
Coinsurance	$870
Limits or exclusions	$150
Total	**$2,520**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $3,250*
- **Patient pays** $2,150*

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$1,500
Copays	$0
Coinsurance	$570
Limits or exclusions	$80
Total	**$2,150**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs and member liability would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.